MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, December 14, 2001
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Adjusting for local differences in resident training costs -- Craig Lisk

MR. HACKBARTH: The next subject on the agenda is adjusting for local differences in resident training costs.

MR. LISK: This is the last presentation for the day. Briefly I'm going to go over -- briefly review. This is a congressionally required study. I'll briefly review the mandate, review the Commission's past views on GME, review the GME payment method, look at what the alternative adjusters are, and the policy considerations you would need in making selection of adjusters, and the potential actions or recommendations you may want to make.

So the congressional mandate, Congress in committee report language asked the following question. Is the physician geographic adjustment factor an appropriate factor to adjust direct GME payments for geographic differences in the cost of physician training? They wanted the Commission to make recommendations by March 2002 on a more sophisticated or refined index to direct GME payment amounts if we found a more refined index to be appropriate for this purpose. I want to emphasize for the Commission here is the if appropriate on here. So we don't necessarily absolutely need to make recommendation if we find the GAF to be appropriate for this purpose.

To briefly review the Commission's views, the Commission has previously stated in its reports on GME, et cetera, that trainees bear the cost of general training by accepting lower wages and paying tuition, and the Medicare education payment should be treated as patient care costs. Now if MedPAC's recommendation were implemented this whole issue would be moot because these payments would be folded into the payment rates, which in that case might imply that the area wage index would be used for adjusting these rates in part.

So let me briefly now review Medicare's payments for physician training. Payments are a product of three factors: hospital-specific per-resident payment amounts, a weighted count of residents, and Medicare's share of patient days. Those are basically the three main components.

The hospital-specific amounts are based on 1984 costs updated for inflation. The BBRA, the Balanced Budget Refinement Act established a floor and rate of increase ceiling for these payment amounts based on a locality-adjusted national rate. The ceiling was set at 140 percent of the locality-adjusted amount. BIPA raised the floor payment rate to 85 percent of the locality-adjusted national-adjusted amount.

The Congress chose to use the 1999 physician GAF for this locality adjustment. I want to point out though is that in the original House version of the bill -- this is what came out of the conference committee -- the original bill passed by the House was somewhat different. They established actually a national rate with a geographic adjustment, so there would have been no variation. Right now there's a corridor of variation that's allowed, but under the House bill there would have been no

variation except for the geographic adjustment. They used the hospital wage index for that geographic adjustment.

So how much variation is there in residency salaries and training costs? What I have up here is showing the variation in first-year stipends based on data from AAMC. Now that data is from 2000-2001, and the payment and cost information is from 1998. So the years aren't quite comparable, but the amount of variation shows at the 10th and 90th percentiles that there's not a lot of variation if we look at a subcomponent of residents' cost in terms of residents' stipends. So it's not a huge amount of variation compared to the variation in per-resident payment amounts before we make these adjustments.

So what are the alternative geographic adjusters that could be used? There's the physician geographic adjustment factor which is the factor that's up there, and the hospital wage index are the two off-the-shelf adjusters that probably could be used, which the Congress considered. There are three main differences between the physician GAF that I think are important to point out, both between the physician GAF and the hospital wage index in both their structure, the number of components of cost that they're measuring, and the weighting scheme that's used, the amount of variation that the indices also reflect, and the geographic areas used for these adjustments.

To get a little more specific so you understand the physician GAF a little bit more, it's a multicomponent fixed weight index. So there's three main components, physician work, practice expense, and malpractice insurance. But in that index it's also important to point out that the physician work component, which makes up about half of it, only 25 percent of the variation in that component is reflected. That's actually by law only 25 percent of the variation is reflected. So it's not reflecting the full variation in those inputs. And they're not measuring actually physician costs. They're using other proxies to measure components of physician salary costs in that component.

The other major factor then is also the area, the geographic area that it's based on. The physician GAF is based on carrier localities, which there are 89 of across the country, and 34 of those are statewide. So it's not as narrow in terms of the areas covered as the MSAs would be with the area wage index.

DR. NELSON: What is the 50th percentile, do you happen to know, in terms of costs? You've got 10th and 90th.

MR. LISK: The 50th percentile, or the average is currently at $98,000 in terms of cost.

DR. NELSON: The 50th percentile is $98,000.

MR. LISK: It's the average. It's not the 50th percentile. It's what the average is. I can't remember what the 50th percentile is.

Then on the hospital wage index only measures one component of cost and that's average hourly wages within an MSA. That's reflecting variation in input mix in terms of the mix of employees hospitals use. That index is applied only to 71 percent of the base cost for hospitals. In our analysis that's what we have -- and the numbers that I'll be presenting, that's

what we're assuming is that the index is applying to 71 percent. That's something that could be discussed if you thought the hospital wage index were a more appropriate index.

So the wage index does reflect variation in labor mix across areas. It is based on 327 MSAs and 48 statewide rural areas.

When we get to these other two indexes that could be potentially used is a residential and teaching physician wage index. Such an index could be developed from the wage index data that's used on the hospital cost reports. So an index would narrowly focus on one component input cost to residency training.

However, there is some issue of quality of that data. There's a potential concern, and I think one of the main issues is a wage index is based on average hourly wages, and what do hours mean for residency training, for instance? I think there's probably a large variation in that versus what variation you would see in actual stipends as shown by the AAMC data. That's one of the problems with potentially developing that data for that use. So if something else was developed you'd need to probably collect some other data than what's off the hospital wage survey.

Another option would be resident payments and costs directly from the cost reports and using that. Such an index for that would reflect variation in input mix across areas. Of course, Congress did not select that. They could have developed an index like that, and it appears they probably did not want to reflect that type of input mix variation across areas, although that's always still a possibility for you to decide on.

Then the final option is really a composite index that could be developed with some combination of the above indices.

The next table shows some of the index levels under some of the options: the physician GAF; the hospital wage index, assuming again it's applied to 71 percent of the payment rate; a resident payment index. So that gives you an idea what the variation is across these selected geographic areas for resident payments and first-year stipends for where we have data from AAMC.

MS. BURKE: Just a quick question. There's nobody in the west --

MR. LISK: Yes, I can give you some idea about the west. Interestingly, salary rates on first-year stipends, for instance -- we didn't have it for 2001 from the AAMC data I had, but in previous information from previous years of cost report surveys they did California, for instance, had lower salary costs, stipend costs for residents in Los Angeles and San Francisco. They were below average in fact, which is fairly surprising given -- their costs have historically been lower than other parts of the country, too.

DR. STOWERS: Craig, about 50 percent of GME is in markets smaller than this. You know, the Tulsas, the Denvers, the non-big academic medical centers. It would be interesting to see what the impact on these are in that. Because this includes only about 50 percent of the GME size.

MR. LISK: Right. Part of this is what I had information on with AAMC data which only reports on where they can get data from more than five providers in a particular market. So they don't

include those submarkets. You see, in terms of the stipends, you still don't see the large variation in stipends. And there are some inconsistencies about how these different indices look across the markets.

Although if you look at the difference between the physician GAF and the hospital wage index and doing a cursory look at from mid-sized to large markets -- not the really small markets -- the greatest difference you see is between -- is in San Francisco where the hospital wage index is 11 points higher than the physician GAF, for instance. If that gives you any kind of indication of that type of stuff.

But there's some wide variation where in some markets, just because of the few hospitals they have, some of those markets have very high per-resident costs for some reason, potentially because of how that hospital allocated those costs. So on that level you'll see greater variation.

Dallas is an example where you see a low per-resident payment amount compared to those other costs. What reason there is for that I'm not certain.

MS. BURKE: What's the current distribution, geographic distribution of residents?

MR. LISK: It's still loaded very much in the east. I can't remember exactly. I think New York trains about close to 20 percent, I believe, of the residents. And there's a lot in Pennsylvania, for instance, and New Jersey, Boston as well. But then you have other markets, Chicago. Los Angeles is pretty big, and certain of those. But those are the big areas.

DR. WAKEFIELD: Craig, will we have the data that Ray was speaking to to inform this piece for the March report, or were you just saying there just aren't data on residents in those smaller --

MR. LISK: No, there is not data on the first-year stipends from AAMC on those smaller markets. But when I showed you then the 10th to 90th percentile you saw what variation in stipends there is: 0.91 to 1.09. There's not a huge variation there. It's a relatively small variation in what's there.

So you need to keep that in mind in terms of the overall picture here of what's appropriate for what you want to do. I think my next slide I want to talk some about what the implications for changing the policy would be.

DR. ROWE: Let me just understand. The actual payment now, the corridor is 0.85 to 1.4; is that right?

MR. LISK: It's 1.4, but the 1.4 is the rate of increase ceiling. So think of those hospitals above that rate increase ceiling are having their payments reduced as much as 12 percent from what they are. So it actually goes way above that. So if someone is 180 percent of the national average, they'll go down to 168 basically, after the full phase-in. So they'll still remain well above the national average given the current policy.

MR. MULLER: But they get reduced by not going up.

MR. LISK: Correct. But the total impact I'd say is about, would potentially be about a 12 percent reduction.

MR. HACKBARTH: Craig, do you want to just go quickly through the remainder of the presentation?

MR. LISK: Yes, that's what I'd like to do, because I think if we look at the implications for the policy changes, one is the floor payments for many hospitals would change, which would affect their payment amounts. Generally, given the alternatives, it would lower a lot of the payment amounts because there's less variation in physician GAF compared to the hospital wage index, although there will be some variation going in both directions.

Different hospitals will be affected by the rate of increase ceiling, which would create some complications on what you do about when one hospital had their payments frozen under one index but wouldn't under the other, and then vice versa, what you would do in that situation in a policy context. We may also change total spending.

So you need to consider also the work involved in changing the index from what's currently used, and whether it's worth the work involved for HCFA or someone else, and whether any alternative index would actually be better, given its current use. Now I think there may be a different opinion if you went to a national payment rate, but I think that's one of the considerations that needs to be made here is whether use of -- given the current use, whether the physician GAF is appropriate.

So in terms of policy considerations -- I'll not say questions here -- policy considerations, you need to consider how well do the alternative indexes track variations in costs, what did the Congress want to achieve with this policy? One was payment relief. Two was narrowing the variation. There's some implications that they wanted -- from some on committee that they were trying to put in a policy the intent of the Commission's recommendation of folding GME payments in without necessarily eliminating the payment by establishing what would have been a national rate.

What type of variation would you want to reflect? Is it input prices or input prices and the mix of inputs used, and does it need to be specific to residency training or not.

And what level geographic aggregation is appropriate? That issue is appropriate if you are developing an alternative index and the number of providers you have to determine what that index level is. Which in many cases, for the wage index, for instance, areas, the MSAs, two-thirds of the teaching hospitals are in markets with three or fewer teaching hospitals, for instance. But there's also the issue of the homogeneity of the markets for resident wages, too, that should also be considered.

So leaving that, the final slide, are the recommendation options, or really what you can do is, one, you can find that the physician GAF is appropriate for this purpose. You could reiterate your recommendation that direct GME payments be folded into patient care payment rates. You could recommend the use of the hospital wage index, or recommend the development of a wage index based on resident and teaching physician wage data. I'll leave it at that for your discussion and answer any other questions.

DR. NEWHOUSE: I've got to run out so I want to say why I want still another option on the table. The variation in cost reflects mostly what went on in 1984, cost allocations and then

how one treats teaching faculty. The spirit of this request to me is, should we adjust for differences in factor prices, which is not the 1984 cost allocations. It's how much I have to pay to get my residents and/or faculty.

What you showed is there's very little variation in that across the country. I'd suggest if we want to adjust for it at all we actually use the historic stipend relatives to adjust. So New York would get 16 percent more than the national average, and so on. Or else we just say the game isn't worth the candle and not worry about it.

But I think the hospital wage index, all of the indices you have down here seems to me to just introduce more noise in the system. It doesn't really correspond to adjusting for what hospitals have to pay to get residents to come to their hospital because they are in a high cost or a low cost of living area.

MS. NEWPORT: I guess my question is more on a process line. Our previous recommendation was -- what in your recommended options -- and I know they're just for discussion -- is it contrary to our previous recommendations, or are we amplifying our previous recommendations? I was struck by your comment in the summary which is basically this issue would be moot if they had but adopted our other recommendations. How do we achieve consistency, or do we need to achieve consistency?

MR. LISK: That's a good question and actually I think the answer to it is, Congress was fully aware when they implemented this policy what the Commission's recommendations were. So you could interpret this as a very specific request to what is the current policy compared to what the Commission previously recommended. Or if you really want to keep reestablishing the Commission's previous positions that would be, you did this, but that's not what we wanted type of thing. So I think those are kind of the two --

MR. HACKBARTH: The other alternative is in the preamble, if you will, say this is what we've recommended in the past but your request reflects that you don't agree with that, so we've been asked a different response, and our response to the question is.

MS. NEWPORT: I think there's value in perhaps reiterating this. I just want to make sure that we're -- okay, you didn't like that so we'll try something else. I think if there's value in what we did before we should --

MR. HACKBARTH: I would not feel comfortable just saying, we stand by our previous recommendation. We will not answer your question. That's not appropriate.

MS. NEWPORT: No, I'm not suggesting that. I wanted to bring that discussion out so that we understand what path we're trying to drive between the two bounds, now that I have a renewed interest in GME.

MR. MULLER: It strikes me we were being asked a narrow question on the index, and obviously all these other discussions like everything else we discuss have to be taken in context. But it strikes me that we're being asked an index question here. We can, as you say, say there's a big, broad discussion to go on here. But my recommendation would be that we focus on the index question rather than on the broader at this time, because I think

the broader issue radiates a lot of our discussions.

DR. ROWE: My sense, recalling the origin of these discussions when I was spending my time differently than I am now, is that the major interest was really in reducing the variation, which was really quite egregious. There were front page articles in the New York Times about the differences between Houston and New York, et cetera. And that the changes that have been put in seem to reduce the variation rather substantially from what it was before with the lowest ones now getting 85 percent of the national, and the highest ones progressively getting ratcheted down.

So I guess my sense would be that after saying that -- after reminding them of our previous recommendation, might sense would be that the system that's in place now is satisfactory. It is not worth the candle of trying to rejigger it again. That's where I am.

MR. HACKBARTH: I would feel comfortable with that also.

MR. LISK: I guess the issue is, do you want to make consensus on that, so the issue of whether we bring this back at the next meeting or not?

MR. HACKBARTH: No, we need to bring it back. We've lost a number of commissioners, so we have to have one more discussion.